IN-HOUSE PATIENT TRANSFER CHECKLIST

*NOTE: *Complete this form for ALL permanent transfers from ER, Short Stay/Radiology, Radiation Therapy, Cath Lab, EPS Lab and ALL in-house unit to unit transfers (including Rehab, SNF, SNU)*
**Complete this form for ALL direct admissions from the Patient Service Center*

Initial entry/Adm to (Clin. Area) Date/Time				
Transfer to (Clin. Area) Date/Time				
Old Medical Records *Comments*	❒ Yes ❒ No ❒ No old chart	❒ Yes ❒ No	❒ Yes ❒ No	❒ Yes ❒ No
Current Chart a. Consent to Treat *(If NO, contact registration)* b. Advanced Directives Questionnaire *(If NO, contact registration)* c. Transfer Order *(If NO, contact transferring staff)* d. Family/Responsible Adult contacted *Explain if "NO" is checked*	❒ Yes ❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No Name: _____ Date/Time: _____	❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No Name: _____ Date/Time: _____	❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No Name: _____ Date/Time: _____	❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No ❒ Yes ❒ No Name: _____ Date/Time: _____
Medications: a. Med Chart b. Refrigerator *Comments*	❒ Yes ❒ None ❒ Yes ❒ None	❒ Yes ❒ None ❒ Yes ❒ None	❒ Yes ❒ None ❒ Yes ❒ None	❒ Yes ❒ None ❒ Yes ❒ None
Addressograph/Blue Plate (with admitting physician's name) *Explain if NOT available*	❒ Yes	❒ Yes	❒ Yes	❒ Yes
Belongings a. Dentures b. Eyeglasses c. Hearing Aid d. Others (as listed on Belongings Sheet) *-- List belongings:*	❒ Yes ❒ None ❒ Yes ❒ None ❒ Yes ❒ None ❒ Yes ❒ None	❒ Yes ❒ None ❒ Yes ❒ None ❒ Yes ❒ None ❒ Yes ❒ None	❒ Yes ❒ None ❒ Yes ❒ None ❒ Yes ❒ None ❒ Yes ❒ None	❒ Yes ❒ None ❒ Yes ❒ None ❒ Yes ❒ None ❒ Yes ❒ None
Signature/Designation (Transferring* Staff)				
Signature/Designation (Receiving** Staff)				

My signature above implies that I have personally checked the presence of the items transferred/received** with the patient, INCLUDING ALL BELONGINGS, unless otherwise indicated in the "comments" section.*

IN-HOUSE USE
PATIENT TRANSFER CHECKLIST
University Hospital

Addressograph